BOOK REVIEW

An Overlooked Consequence of Globalization: Exporting American Notions of Mental Illness and Mental Health

（グローバリゼーションの見落とされた影響：アメリカの精神疾患及びメンタルヘルスの拡大）

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BOOK REVIEWED:
Ethan Watters. *Crazy Like Us: The Globalization of the American Psyche*. New York: Free P, 2010.

Most of the disasters in the world happen outside of the West. Yet we come in and we pathologize their reactions. We say 'You don't know how to live with this situation.' We take their cultural narratives away from them and impose ours. It's a terrible example of dehumanizing people.

–Arthur Kleinman, medical anthropologist, Harvard University [1]

The spread of the PTSD diagnosis to every corner of the world may, in the end, be the greatest success story of globalization.

–Allan Young, medical anthropologist, McGill University [2]

Among the vast amount of research and scholarship conducted on the topic of the effects of globalization in today's world, very few have

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delved into the realm of mental health, specifically mental illness or mental disorders. When we think of how globalization has affected various segments of the world, we usually think of economics and the transfer of commodities such as McDonald's hamburgers and Nike sneakers, or in terms of the impact of globalization on the environment, on poverty, and on education or political thought. Rarely do we think of ways in which globalization affects how mental illness is conceptualized, shaped, experienced, diagnosed, and treated. Ethan Watters in his 2010 book *Crazy Like Us: The Globalization of the American Psyche* sets out to do precisely this: to extend the analysis of globalization to the realm of human psyche.

The book, *Crazy Like Us*, is divided into four sections each focusing on a different mental illness in a different region of the world, beginning with anorexia nervosa in Hong Kong, post-traumatic stress disorder in Sri Lanka, schizophrenia in Zanzibar, and depression in Japan. Watters, an investigative reporter also known for his coverage of the research on how false memories about experiences of violent sexual and psychological abuse can be induced and who himself is married to a psychiatrist, is well-versed in the culture of the Western mental health profession. In *Crazy Like Us*, Watters travels across different continents to investigate the implications and consequences of exporting Western ideas of mental illness and treatment practices, offering compelling examples along the way. Watters also adopts a cultural psychological perspective as if he had been trained under the tenets of the discipline of cultural psychology, making this an excellent supplemental reading for a college-level cultural psychology or psychological anthropology course.

One of Watters' contributions is the way in which he integrated the realm of mental disorders with the cultural psychological paradigm of mutual constitution. The philosophical underpinnings of the field of cultural psychology have been discussed extensively by Richard Shweder, a cultural anthropologist from the University of Chicago, who defined cultural psychology as an approach distinct from that of general psychology. Shweder (1990) argues that general psychology characterizes the mind as a central processing mechanism that can be isolated from its social and physical environment. If the universe is analogous to the mind, it would be similar to how Newton conceptualized the universe as being independent of its contents (e.g., nebulae, stars, planets, etc.). Cultural psychology, on the

other hand, assumes that mental functioning cannot be separated from its environment, that the mind and environment are constantly mutually constituting each other, similar to how Einstein conceptualized the universe as being literally shaped by its contents.

> Cultural psychology is the study of the ways subjects and object, self and other, psyche and culture, person and context, figure and ground, practitioner and practice, live together, require each other, and dynamically, dialectically, and jointly make each other up. (Shweder, 1990, 41)

The above notion of "mutual constitution" may appear as common sense to some, however, is often not an easy concept to grasp. Take the example of post-traumatic stress disorder or more commonly known today by its acronym PTSD. If one subscribes to the idea that people from different cultures respond in similar ways to a traumatic, often violent event, and that there should be a standard approach to diagnosing and treating people with PTSD, then one is subscribing to the principle of general psychology. General psychology assumes that regardless of the individual's cultural and historical heritage and context, the individual will exhibit similar symptoms which should be resolved through a universal treatment strategy, rather than assuming that the experiences of a traumatic event are shaped by collectively shared ideas and practices within a community that inform how such an event might be interpreted and responded to.

In his first chapter on anorexia nervosa in Hong Kong, Watters describes how the diagnoses of anorexia nervosa, previously unknown and rarely reported in Hong Kong—at least in the way it is conceptualized in Western-based diagnostic manuals which highlight a preoccupation with body image—suddenly saw a dramatic rise in a short period of time during the 1990s among the Hong Kong Chinese. Here, Watters critically examines the evoked conventional wisdom that when incidence of a particular type of mental illness increases, there is a tendency to assume that the illness "in question had previously gone unnoticed or underreported" (32). Instead, he suggests that perhaps we are neglecting the alternative possibility that psychiatrists, physicians, and patients, once exposed to a Western narrative for a particular form of suffering, together become active players in a co-constructive process of shaping the way suffering is experienced. In this way, an experience that

previously failed to fit any available narrative now fits the new narrative that has just recently become available for them to make meaning of that suffering.

Watters cites the work of Edward Shorter, a medical historian and an expert on the history of anorexia that emerged during the Victorian Era (around 1837 to 1901). Shorter argued that the only way to understand the Western evolution of anorexia is to "see it in the context of the archetypical psychological diagnosis of the nineteenth century: hysteria" (27). In the early 1850s, a few isolated cases of adolescent girls who refused to eat were being recorded. Eventually, doctors began to debate about the meaning and cause of the illness and began suggesting a formal diagnostic label. After such "incubation" period of the illness debate, doctors "began to shape the public's and the patients' understanding of the behavior" (30). Doctors, too, are human in that they have their own motivation to advance their careers by bringing attention to a rare and emerging illness. Shorter argues that patients, too, actively strive for recognition and legitimization of their own internal distress by speaking "in a language of emotional distress that would be understood in its time" (32). It was after this incubation period that the number of recorded incidence of anorexia began to rise dramatically. It also should be noted that psychosomatic illnesses tend to shift over time so that when the diagnosis of "hysteria" fell out of favor, the incidence of anorexia dwindled down to as few as one a year in the mid-1900s.

Watters suggests that mental illness does not exist in a vacuum to be "discovered" but is negotiated by doctors and patients under the existing meaning making tools available at the time. Sing Lee, a psychiatrist in Hong Kong and an expert on eating disorders, concluded about the rising incidence of anorexia nervosa in Hong Kong that "there may be no true natural history of anorexia nervosa, but rather a social history at a given time and place, a perspective which questions radically the biomedical assumption that there is a 'core problem' with anorexia nervosa" (35).

An often overlooked consequence of globalizing mental illness labels and their symptom profiles, according to Watters, is the power dynamics or power differential which elevates Western mental health practices as superior to that of the mental health practices of the non-Western local communities. Western mental health practitioners are overconfident that their understanding of mental illness is based on sound scientific practice founded on empirical

evidence, and can be applied to non-Western cultures. The power of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is an example. The DSM is a manual that provides a classification of mental disorders based on empirical studies that have been historically based in Western nations. Yet, while being empirical, the DSM is also completely atheoretical. It simply provides statistical clustering of symptoms and the labeling of those clusters with a database that represents largely, if not only, Western psychiatric patients. Thus, there are obvious problems with applying DSM criteria for mental illness universally, since the database upon which it is based represents a very narrow slice of humanity. However its impact on less developed nations as a "legitimate" source of knowledge about mental illness is quite powerful. This is perhaps one of the most important lessons of the book, though it is one that is not highlighted in a way that may end up sticking for many readers.

To illustrate this kind of cultural hegemony, Watters discusses in his second chapter the December 2004 disaster of the Indian Ocean tsunami hitting the shores of Sri Lanka, Indonesia, India, and Thailand, devastating the coastal towns in those countries. Large-scale relief efforts were immediately launched and hundreds of Western psychological aid workers flocked to Sri Lanka just days after the disaster struck. The problem, according to Watters, was that these Western psychological aid workers had little understanding of the culture of the region they were entering. He illustrated how these relief workers clearly lacked the understanding that people from different cultures might differ in how they deal fundamentally with traumatic events, and seldom met with local leaders to ask about the local communities' need—they didn't see the point in doing so since they were confident that they had the answers. Even more detrimental was that as a result of insisting upon employing Western methods of intervention in treating trauma, indigenous healing practices that have worked for centuries in these communities were undermined, discredited, and silenced.

The mental health practitioners were not the only ones to arrive in Sri Lanka—there were also the researchers who saw this as opportunity to study PTSD symptoms with Western-developed assessment tools. The researchers came into Sri Lanka in the hundreds, each competing for subjects for their own study. However, it was questionable how effectively the assessment

tools based on a Western samples captured the relevant symptoms and concerns of the Sri Lankans. Watters explains:

> Sri Lankans were much more likely to experience physical symptoms after horrible events. . . . Without the mind-body disconnect common in Western thinking, these Sri Lankans reacted to the disaster as if they had experienced a physical blow to the body. . . . By and large Sri Lankans didn't report pathological reactions to trauma in line with the internal states (anxiety, fear, numbing and the like) that make up most of the PTSD symptom checklist. Rather Sri Lankans tended to see the negative consequences of an event like the tsunami in terms of the damage it did to social relationships. . . . In short, they conceived of the damage done by the tsunami as occurring not inside their mind but outside the self, in the social environment. (91)

Thus, it is questionable how valid the use of these pre-existing instruments to faithfully tap into the symptomatology of the Sri Lankan survivors of trauma.

Moreover, Western counselors that arrived in Sri Lanka after the tsunami disaster thought of themselves as "emergency medical professionals treating wounds at the scene of the accident" which meant that they were delivering "the psychological equivalent of applying clean dressing to fresh wounds" (75). In essence, the fundamental idea underlying this approach was to not be the least interested in their religious beliefs, traditions, or social structures because of the notion that this was a universal approach of providing emergency first aid such as applying bandages to a wound. The idea that dealing with the psychological trauma was as important as providing disaster reliefs such as medicine, food, and shelter had taken hold. Watters quotes a psychiatrist saying that the concern over psychological trauma had "displaced hunger as the first thing the Western general public thinks about when a war or other emergency is in the news" (71).

In his third chapter on schizophrenia in Zanzibar, Watters discusses the negative impact of Western-based biomedical models of mental illness. Schizophrenia is a group of several disorders characterized by disorganized and delusional thinking, disturbed perceptions, and inappropriate emotions and actions. This chapter is perhaps the most surprising to the reader of an industrialized and developed country, as it points to studies that suggest how

people suffering from schizophrenia fared far better in developing countries than in developed countries (Jablensky & others, 1992). For example, the patients in non-industrialized countries such as India, Nigeria, and Columbia, were much more likely to recover from their symptoms without relapse than in industrialized countries such as the United States, Denmark, or Taiwan (Jablensky et al., 1992). Sixty-three percent of patients in non-industrialized countries showed full remission compared to 37 percent in industrialized countries (Jablensky et al., 1992). Evidence from cross-cultural research clearly points to the fact that the manifestation and experience of the illness are deeply rooted in cultural context and should be interpreted, experienced, and treated according to the existing folk explanations for the occurrence and onset of it. At the same time, differences in social support structures, such as whether or not large extended families exist, appears to play a role in the prognosis of this illness. With respect to how those suffering from schizophrenia are treated, those who suffer from schizophrenia in non-industrialized countries are less likely to be institutionalized and more likely to continue to be active, inclusive, and contributing members of their communities than is the case in industrialized countries (Lin & Kleinman, 1988). There is also the fact that people in non-industrialized countries are less likely to think of the illness as a "permanent" part of the person and therefore are less likely to maintain social distance from such a person. Thus, those suffering from schizophrenia in developing countries suffer less from the stigma than those in developed countries since the illness is less likely to be thought of as an "essential" part of the person (Schnittker, 2008).

One of the most detrimental outcomes of the globalization of Western psychology, according to Watters, was the promotion of the biomedical model of mental illness. The biomedical model for understanding mental illness such as schizophrenia is essentially this—that schizophrenia is an illness of the brain, and that the mind is broken. The mind needs to be fixed through chemical substances (i.e., drugs). Western doctors have always believed that having a biomedical explanation for an illness results in less stigma for the one with the illness. However it turns out that those who adopted the biomedical model of mental illness were most often those who wanted less to do with the mentally ill or considered them to be unpredictable, dangerous, and unstable. In the United States, for example, during the forty-year period between the 1950s and 1990s, attitudes toward the mentally ill

changed steadily in the direction of perceiving the mentally ill as increasingly dangerous. The irony is that the biomedical explanation about an illness comes with the assumption that individuals are not responsible for their deviant behavior but at the same time such individuals are perceived as being more thoroughly broken and permanently abnormal compared to individuals who are thought to be ill because of life events. Hence the illness is assumed to be more of an internal essence of the person rather than life circumstances of something that is caused by an external force (e.g., spirit possession) (173).

In this chapter, Watters introduces us to Juli McGruder, a cultural anthropologist who conducted extensive ethnographic research with several Zanzibar families. In one family, McGruder watched a woman named Shazrin who was suffering from schizophrenia being treated with traditional healers initially but then began being treated by a doctor with a Western biomedical understanding of schizophrenia. This is somewhat of a tragic tale. Shazrin at the beginning of her illness was thought to have been possessed by spirits caused by a sighting of a black cat. But once her relatives were thoroughly indoctrinated in the Western biomedical model of the illness, they treated her as if her mind was broken but can be controlled with medication, leading to dehumanization and control by the relatives. It is therefore quite possible that the medical model has in essence worked to strip those suffering from a mental illness from the feeling of being connected to their communities and from feeling that they are meaningful and productive members of their communities and instead enhanced their sense of isolation as well as their sense of having an inherent pathology that needs constant monitoring and control by others.

In the fourth and final section of the book before the brief concluding chapter on the broader consequences of globalization, Watters ends his journey in Japan to discuss perhaps the most chilling and insidious of the four cases: the explicit marketing of a disorder in order to manufacture consumer demand for a drug to treat that disorder. While the preceding three sections spoke to the globalization of the American conception of mental illness as a consequence of a cultural imperialism steeped in ethnocentrism and/or a denial of the role that culture can play in the experience, expression, and consequences of forms of human suffering, this section examined a case in which such knowledge was explicitly exploited for the sake of maximizing profits for a single multinational pharmaceutical company.

Watters begins the section by introducing the reader to Laurence Kirmayer, a transcultural psychiatrist from McGill University, who was invited to a closed-door convention in Kyoto, Japan in order to talk about his work on the cultural shaping of mental illness. Although the convention was sponsored by pharmaceutical giant GlaxoSmithKline, it is not entirely unusual for a legitimate convention on mental health to be sponsored by a private corporate entity. Yet, there were a number of red flags that were raised during this trip for Kirmayer. From the first class seat on the transcontinental flight to the five star hotel and other luxurious amenities during his stay in Japan, there was no doubt that Kirmayer was being given the royal treatment the likes of which only a millionaire could experience. Second, it was only upon his arrival in Kyoto that Kirmayer learned of the closed-door rule of the convention, barring even one of his own star graduate students who was already in Japan from attending it.

Kirmayer quickly came to realize that the reason for the royal treatment and secrecy of the meeting was to serve in the direct interest of a mega-marketing campaign that GlaxoSmithKline had in mind. Specifically, GlaxoSmithKline and the scientists they hired to take diligent notes at the meeting were there to learn about the cultural beliefs about depression and the possibilities of how such beliefs can be reshaped to fit a different narrative than the existing one. Indeed, the Japanese cultural attitude towards chronic states of sadness was historically one that was fundamentally different from those of Westerners.

Watters, drawing on the work of Junko Kitanaka, Kirmayer's star graduate student who was barred from attending the convention in Kyoto and who wrote an award-winning dissertation on the cultural history of depression in Japan, discusses the Western assumption that low arousal negative states such as depressed moods are undesirable emotional states and are in diametric opposition to the more desirable, high arousal positive states like elation and happiness. (As a side note, this knowledge is also consistent with recent evidence in cultural psychological research on emotions by scholars like Jeannie Tsai at Stanford University). According to Kitanaka, Japan, in contrast, has had a history of romanticizing sadness and associating such states with existential moral struggles of elite Japanese intellectuals of early 20th century. Thus, such depressed mood states reflected a sophisticated moral character and were even reflective of a coveted status symbol in late 19th century

Japan. At the same time, due to influences of German neuropsychiatry, Japanese psychiatrists also recognized a very severe kind of an "endogenous" depression which only afflicted a few people because it was regarded as equivalent to a psychotic disorder, requiring long-term institutionalization.

Japan thus regarded depression in its mild form as an index of desirable moral character and in its severe form as a rare, psychotic-like, disorder far removed from the experience of ordinary citizens. Yet, multinational pharmaceutical companies like Eli Lily and Pfizer relied on a conception of depression as an experience of mild to severe emotional distress which can afflict anyone and for which anyone would want relief, a relief in the form of transforming a negative low arousal emotional state into a more aroused, positive emotional state, something that SSRIs like Prozac can supposedly accomplish. Even as recently as the late 1990s and early 2000s, this conception of depression did not exist in Japan. Consequently, Eli Lilly and Pfizer decided that there was no market for their SSRIs in Japan.

Rather than choosing to conclude that their own antidepressant, Paxil, was not marketable in Japan, GalxoSmithKline decided to think outside the box. They reasoned that if transcultural psychiatrists like Kirmayer are suggesting that the conception, experience, and expression of depression can be culturally shaped, then they can manufacture the demand for Paxil through a series of ingenious marketing ploys. Such approach would serve to reshape the conception of depression so that what was previously considered a normative, or even a desirable,emotional state, is reconceptualized as an experience that is construed as a common, yet unhealthy emotional state requiring medical treatment. In order to market this cultural message, GlaxoSmithKline, in collaboration with local psychiatrists, began in the early 2000s to sell the idea that depression was a "cold of the soul" or *kokoro no kaze*. This phrase implied that anyone could become depressed, just like anyone could catch a cold, and that there was a pill that can relieve this common kind of suffering. Yet, the idea of catching a cold may not necessarily convey an urgency to seek treatment, which was also problematic for GlaxoSmithKline. Consequently, the company capitalized on a controversial law suit case that was receiving widespread media attention at the time in which the family of a young adult son who committed suicide was suing the company their son worked for because they blamed the company for overworking their son to the point of driving him to suicide. The case went on to appellant court

where there was a ruling in favor of the family. The take home message of this case was that depression can lead to suicide, and this was the first time that depression and suicide were associated with each other in the Japanese public consciousness. Thus the idea sold by GlaxoSmithKline was that while depression is a common form of suffering, as common as the common cold, it can also be life-threatening if left untreated.

GlaxoSmithKline was also coincidentally helped by a Japanese TV producer who happened to be browsing the English books section in a bookstore and picked up a best selling book in the United States at the time, Peter Kramer's *Listening to Prozac*. After reading through the book and being fascinated by the subject matter, he decided to produce a widely watched TV documentary on depression and SSRIs. As a result of this TV documentary, many Japanese began asking their own doctors about getting treatment for even mildly depressed emotional states.

The next obstacle that GlaxoSmithKline had to overcome was the fact that marketing prescription drugs directly to consumers is illegal in Japan. However, it is not illegal to publicly campaign to recruit volunteers for drug studies and/or to educate the Japanese public about a public health issue. Exploiting this loophole, GlaxoSmithKline bought TV and magazine ads to educate the public about the symptoms of depression and to encourage people to ask their doctors about the appropriate treatment if they are experiencing such symptoms or have doubts about the symptoms they are experiencing.

To the Western reader, GlaxoSmithKline may have simply be acting in good conscience, as it can be easily argued that they were simply educating the Japanese about a disease that many Japanese already suffer from but had no recourse for. Indeed, in interviewing a few executives in the company, Watters indicates that these people genuinely believed that it was their duty to help Japan "catch up" to the "good science" of the treatment of depression that most Americans took for granted. Thus, like the conceptualization of PTSD by many mental health professionals, these company executives failed to consider their own active roles in socially constructing a narrative which allows people whose minds become unstuck for whatever reason to express their suffering in a form that fits that particular narrative in place of a previous narrative that may have ultimately been less pathologizing and therefore less consequential. Yet, in this case, they were not only complicit in potentially doing more harm than good in "essentializing" a normative emotional state.

Watters also argues that these executives are misguided in their blind faith of the science behind the drugs they are marketing. At this point, Watters delves into the questionable scientific claims about the link between depression and Serotonin, a neurochemical SSRIs specifically target to supposedly relieve depressive symptoms. Watters then further discusses recent scandals in the pharmaceutical industry of a pattern of behavior to ghost write academic papers and/or pay off academics to write scientific papers which exaggerate the benefits of SSRIs while downplaying any evidence suggesting their lack of efficacy or even their negative consequences.

While reading almost half a chapter on the fraudulent practices of the pharmaceutical industry to misrepresent the scientific and clinical merits of SSRIs is certainly provocative for the reader, there seems to be a disconnect between such a discussion and the central theme of the rest of the section in the book. This disconnect gives the reader the feeling that Watters may be tainted by an anti-pharmaceutical industry agenda which he has injected into the book.

Another criticism of the book is that Watters chooses not to flesh out any of the controversies surrounding the central thesis of the book, which is that the experience, expressions, and consequences for any given mental illness are culturally and historically variable and that American psychiatry is unilaterally globalizing the diverse cultural landscape of mental illness. A critic of this perspective might easily point out that what was once referred to as "hysteria" during Freud's time is today referred to as "conversion disorder" according to the DSM. Therefore, one may not be able to easily suggest that hysterical symptoms during Freud's time were largely associated with the Victorian era of sexual repression of the time, as others have suggested, if those symptoms are equally prevalent today under a different diagnostic category. Furthermore, since there are no known epidemiological studies conducted on hysteria in the late 19th century, we do not know whether hysterical symptoms were necessarily more prevalent then than they are now. While Watters' arguments do follow the central tenants of cultural psychology in suggesting that cultural contexts and cultural ideas shape our perceptions and psychological experiences, cultural psychology has generally focused on social behaviors rather than on mental illnesses. Therefore, thoroughly fleshing out any controversies around the theory of cultural shaping of mental illness would have probably been a logical transition into the concluding remarks of

the book rather than splitting off and devoting a section in a chapter to discuss the scientific and practical merits of SSRIs.

Notwithstanding these criticisms, the book does provide well-written and compelling cases that would force any clinical psychologist, psychiatrist, or the lay person who reads it to seriously consider how deep culture can go in affecting the human psyche. Given how notorious clinical psychologists and psychiatrists are in dismissing the profound impact of culture relative to how other social scientists think about culture, there is no doubt that Watters has done a service to the mental health profession in writing this book. It is our hope that more of such books that take an ethnographic approach to illness and culture will continue to emerge and enlighten us about the strong connection between mind and culture, illness and culture, and to caution us away from embracing with full force the overly simplified, unrealistically "universal" model of the mind. The mind is a product of cultural meanings, practices, and institutions that infuse our everyday lives, as well as our individual unique histories. One cannot separate the mind from the cultural and sociohistorical context that it is engaged with.

> *We've invited people to see a widening range of experiences as liable to make them ill. This becomes a problem because we are globalizing our culture. We are presenting just one version of human nature—one set of ideas about pain and suffering—as being definitive. In truth, there is no one psychology.*
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> *—Derek Summerfield, Kings College*[3]

Notes

1. Watters (2010), 107.
2. Watters (2010), 71.
3. Watters (2010), 123.

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